Appendix 7 Sample HCFA 1500 Claim Form

PICA										SURANCE CLAIM FORM PICA TIAL INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)							
MEDICARE MEDICAID (Medicare #) (Medicaid			HAMPVA (VA File #	HEA	OUP LTH PLAN N or ID)	FEC/ BLK	A OTHER LUNG SN) (ID)		'S I.D. NU 45678			(FOR PR	ROGRAI	M IN ITEM 1)		
PATIENT'S NAME (Last Name,		· Ш			S BIRTH DATE		SEX	4. INSURED'S			ne, First	Name,	Middle II	nitial)			
Recipient, Im A.	,			MM I	OD YY	м	FX										
PATIENT'S ADDRESS (No., St	reet)				RELATIONSH	IP TO	INSURED	7. INSURED'S	3 ADDRES	3S (No.,	Street)						
609 Willow					Self Spouse Child Other				·								
N mortovem			STATE	8. PATIENT	STATUS	_		CITY							STATE		
Anytown	TELEBHONE (ledu	do Area Cor		Single	Marrie	d [Other	ZIP CODE			TELE	PHON	E /INCLI	IDE 45	REA CODE)		
P CODE TELEPHONE (Include Area Code (XXX)XXX-XXXX			Employed Full-Time Part-Time					ZIF CODE			, ere	, LUCINI))	JUE AF	TEA CODE)		
3333 OTHER INSURED'S NAME (La				10. IS PATI	Student ENT'S CONDIT		Student RELATED TO:	11. INSURED	'S POLIC	Y GROU	PORF	ECA NU	JMBER				
)I-P																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO				a. INSURED'S DATE OF BIRTH SEX									
OTHER INSURED'S DATE OF BIRTH SEX				b. AUTO ACCIDENT? PLACE (State)				b. EMPLOYER'S NAME OR SCHOOL NAME									
M F				YES NO													
. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER A		NO	c. INSURANCE PLAN NAME OR PROGRAM NAME										
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCA							NO SE	d IS THERE	ANOTHE	RHEALT	HEENE	FIT DI	AN?		-		
				TOU. NEGER	., LU I ON LOC	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ff yes, return to and complete item 9 a-d.											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment								Insured Section 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
below. SIGNED								SIGNED									
MM DD YY INJURY (Accident) OR PREGNANCY(LMP)				IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				FROM DD YY TO MM DD YY									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 1.M. Referring Physician				a. I.D. NUMBER OF REFERRING PHYSICIAN 11223344				16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO TO									
RESERVED FOR LOCAL USE	·							20. OUTSIDE	LAB?	-1		\$ CHA	1				
								YES		40 I		,		1			
DIAGNOSIS OR NATURE OF	ILLNESS OR INJUR	Y. (RELATE	ITEMS 1	,2,3 OR 4 TO	ITEM 24E BY	LINE)		22. MEDICAII	RESUBI	MISSION	ORIG	INAL R	EE NO	J			
1. V72.6					_		*	23. PRIOR AUTHORIZATION NUMBER									
			4	· L													
DATE(S) OF SERVICE	B Place	C Type PR	OCEDUF	D RES, SERVICI	ES, OR SUPPL	JES	E DIAGNOSIS	F		DAYS			J	BESE	K RVED FOR		
From M DD YY MM	To of DD YY Service	of		in Unusual Cir	rcumstances)	.	CODE	\$ CHARG	GES	OR UNITS	Family Plan	EMG	сов		CAL USE		
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FEDERAL TAX I.D. NUMBER	SSN EIN	1		CCOUNT NO	27. AC	CCEPT r govt.	ASSIGNMENT?	28. TOTAL CH		1	amol		1		LANCE DUE		
CICNATURE OF BUYOUS	OD SYRDENIED		34JE			YES	NO SERVICES WERE	\$ 33. PHYSICIA	XX				XX	\$	XX X		
SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR C (I certily that the statements or apply to this bill and are made	REDENTIALS the reverse	SZ. NAM REN	AE AND A	If other than I	nome or office)	iene S	CHVICES WERE	8 PHONE	11 5, SUP :#	FLIER'S	BILLIN	u naivi	⊏, AUUF	1500, Z	IL CODE		
GNED	DATE							PIN#			ا	iRP#					
JINCH!	DV1E	-						1.00			FORM						